Coastal Pain and Spinal Diagnostics

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Follow-Up Questionnaire

PATIENT INFORMATION

Name: _____ **DOB:** ___/___/___ **Age:** _____

Today's Date: ___/___/___ **Height:** _____ **Weight:** _____

TODAY'S VISIT

What is the reason for today's visit? (Please circle all that apply): **Post-Procedure Assessment**

New Problem **Medication Refill** **Review Imaging/Labs** **Other:** _____

Which provider will you be seeing today?: _____

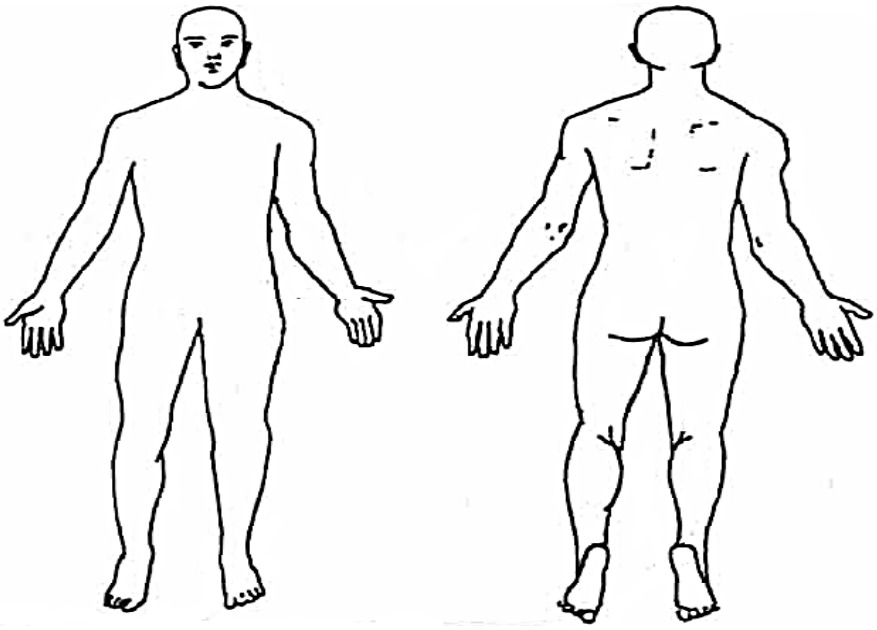
SINCE YOUR LAST VISIT

Is your pain better, worse or the same? (Circle One): **Better** **Worse** **The Same**

Do you have any NEW concerns?	☐ NO	☐ YES	**Please List:**_____
Any NEW medical problems or surgeries?	☐ NO	☐ YES	**Please List:**_____
Any NEW medication side effects?	☐ NO	☐ YES	**Please List:**_____
Are you on any NEW medications?	☐ NO	☐ YES	**Please List:**_____
Any NEW imaging studies or lab work?	☐ NO	☐ YES	**Please List:**_____
Do you have ANY allergies?	☐ NO	☐ YES	**Please List:**_____
Are you seeing any NEW providers/doctors?	☐ NO	☐ YES	**Please List:**_____
Are you on ANY blood thinners?	☐ NO	☐ YES	**Please List:**_____

CURRENT PAIN DETAILS

Please use the following symbols to fill in the diagram below:



N = **Numbness**
\+ = **Sharp**
✳ = **Burning**
Δ = **Aching**
// = **Pins & Needles**
✓ = **Shooting**
○ = **Other:**_____

Answer the following by circling a number from 0 (no pain) to 10 (worse pain imaginable):

What is your *Current* pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

What is your *Average* pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____

CURRENT PAIN DETAILS

Have you developed any of the following, since your last visit?:

- ☐ Numbness
- ☐ Weakness
- ☐ Bowel Incontinence
- ☐ Bladder Incontinence
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Difficult Walking
- ☐ Balance Problems
- ☐ Chills
- ☐ Fevers
- ☐ Poor Sleep
- ☐ Fatigue
- ☐ Vomiting
- ☐ Nausea
- ☐ Current Infection
- ☐ Paresthesias
- ☐ I have not recently developed any of the above problems

REVIEW OF SYSTEMS

Do you have or have you ever had any of the following diseases or conditions?: (Please circle all that apply)

GENITOURINARY

Urinating Frequently
Urinating Urgency
Painful Urination
Kidney Stones
Blood in Urine
Kidney Disease
Flank Pain

SKIN

Dryness
Itching
Rash
Ulcers
Shingles
Seasonal Allergies
Hay Fever

RESPIRATORY

Shortness of Breath
Cough
Wheezing
Pulmonary Embolism

ENDOCRINE

Cold Intolerance
Heat Intolerance
Hot Flashes

GASTROINTESTINAL

Abdominal Pain
Liver Disease
Diarrhea
Constipation
Acid Reflux/Heart Burn
Hernia
Blood in Stool
Irritable Bowel Syndrome
Ulcer Disease
Nausea/Vomiting

MUSCULOSKELETAL

Back Pain
Neck Pain
Joint Pain
Joint Swelling
Muscle Spasms
Joint Stiffness
Skin Temperature Changes
Skin Color Changes
Increase Sensitivity to Touch
Edema

NEUROLOGICAL

Carpal Tunnel Syndrome
Headaches
Dizziness
Weakness
Numbness
Tremors
Seizures
Loss of Balance/Coordination
Stroke
Migraines
Dementia
Hydrocephalus

CONSTITUTIONAL

Fevers
Chills
Night Sweats
Excessive Sweating
Loss of Appetite
Insomnia
Tremors
Fatigue
Unexplained Weight Loss or Gain

CARDIOVASCULAR

Bleeding Disorder
Chest Pain
Fainting
Dizziness
Swelling in Feet
High Blood Pressure
Shortness of Breath
Blood Clots
Irregular Heartbeat
Murmur
Pacemaker
Angina
Heart Failure

Head/Eyes/Ears/Nose/Throat

Blurred Vision
Ringing in Ears
Vertigo
Hearing Loss
Dry Mouth
Sinusitis
Abnormal Smells
Dental Issues
Nosebleeds
Earaches
Sore Throat
Sinus Problems
Difficulty Swallowing
Glasses
Excessive Tearing
Cataracts
Glaucoma

PSYCHIATRIC

Depression
Anxiety
Stress
Difficulty with Thinking
Poor Sleep

REPRODUCTIVE

Inability to Have Sex Due to Pain
Decreased Sex Drive